GALYA RAJANAGARINDRA INSTITUTE
DEPARTMENT OF MENTAL HEALTH, MINISTRY OF PUBLIC HEALTH
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TEL. (66) 2-4416100

MEDICAL CERTIFICATE

Date.....

To whom it may concern,

This certifies that.....

ID/PASSPORT NUMBER.....

HN..... Age.....years Sex.....

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Diagnosis

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Medication

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Recommendation

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(, MD)

Attending Physician

Licence Number : .....

..... Patient/recipient

(.....)